STATE OF IOWA

FMLA FITNESS FOR DUTY CERTIFICATION

Section 1: Instructions for the DEPARTMENT:

Attach a copy of the employee's essential job functions and regular work schedule/hours.

Section 2: Instructions for the EMPLOYEE:

You are required to have this fitness for duty certification completed by the health care provider who has knowledge regarding your reason for using FMLA. Submit the completed form to your supervisor within at least two business days prior to your return to work. Your supervisor will then forward this form to human resources to be placed in your medical file.

Employee Name (print): _____

Department: _____

Supervisor: _____

Date Leave Began: _____ Expected Date of Return: _____

If leave was for a continuous block of time and my health care provider has released me to return to work:

❑ Yes I intend to return to work as scheduled.

❑ No I do not intend to return to work and I am resigning my employment with the State of Iowa.

I ❑ authorize ❑ do not authorize (check one) the health care provider identified below to provide the information requested on this form for the purposes of determining my fitness for duty.
I ❑ do ❑ do not (check one) give my employer permission to contact the health care provider to authenticate and/or clarify the information if needed. I understand that if I do not agree to this authorization, my return to work may be delayed or denied.

Employee's Signature: _____ Date: _____

An employee who fraudulently obtains FMLA leave will be subject to disciplinary action, up to and including termination.

Section 3: To be completed by the HEALTH CARE PROVIDER:

Instructions to the Health Care Provider: Please review the employee's work schedule and essential functions (attached) and answer the following:

❑ Yes ❑ No I have reviewed the essential functions of the above named patient's job.

I have examined the above named patient and certify that s/he is able to resume working:

____ Full-time, or
____ Less than full-time

❑ Yes ❑ No **The patient is able to perform the essential functions of the position that are attached with no restrictions.**

If yes, the employee is fully released to return to work on _____ (date)**.**

If no, the employee is released with restrictions to return to work on _____ (date)**.**

Please list the essential functions the employee is unable to perform until _____ (date) **or ❑ permanently**.

_____

_____

Additional Comments:

_____

_____

Health Care Provider Information:

Signature: _____ Date: _____

Printed Name: _____ Type of Practice/Specialty _____